PROVIDING ORAL HEALTH CARE
TO ELDERLY IN LONG-TERM CARE FACILITIES

WHY PROVIDE/HISTORY/NEEDS

According to the North Dakota State Data Center, North Dakota is experiencing an increased population of elderly individuals older than 65. In 1980, 12.3 percent of the population was in this age range; while 14.7 percent were older than 65 in 2000. North Dakota also has the highest proportion of elderly in the United States over the age of 85. There is a growing trend of elderly individuals coming back to North Dakota to be closer to family members. This trend will increase dramatically as baby boomers age. If this trend continues, the elderly population will grow by 58 percent over the next 20 years and their numbers will represent 23 percent of the state population. Most elderly individuals are on fixed incomes and have some of the lowest incomes in the state. Coupled with increasing medical health issues, they have limited funds for expenditures on oral health care at a time when ignoring these needs compounds health issues and quality of life. A large number of these elderly people are placed in long-term care facilities and/or assisted living facilities. Sixty percent of individuals placed in long-term care facilities are on Medicaid (Source: North Dakota Long-term Care Association). Being a Medicaid recipient on a fixed income, as well as being a patient in a nursing facility, further decreases access to oral health care. Currently, in the Bismarck-Mandan area there are 12 nursing homes or assisted living facilities. None have oral health care on any routine basis. Some individuals are able to be transported to private dental offices if they had previously been a patient of record. The cumbersome process of transporting the elderly and the long waits for return transportation make these oral health visits less than satisfactory, tiring and trying for the aging population.

Poor oral health and untreated dental conditions are a serious problem for nursing homes, especially because older individuals are more prone to tooth decay. For instance, roughly one-quarter of adults older than 65, have severe periodontal disease and adults age 75 or older represent the adult age group with the lowest percentage of annual dental visits. Untreated dental conditions can cause residents severe pain, malnutrition, social isolation and severe dental disease. Dental health contributes to overall health and can be a prelude to complications of certain medical conditions. Studies show correlations between gum disease and heart disease. Periodontitis shares risk factors with chronic degenerative diseases such as ulcerative colitis. Oral symptoms can be indicators of heart and liver disease, eating disorders, diet deficiencies, diabetes, arthritis, osteoporosis and some autoimmune diseases. Dental plaque is a breeding ground for bacteria and fungi that promote respiratory pathogens that cause pneumonias. Some studies show aspiration pneumonia is attributed to poor oral health and dental plaque. Additionally, most elderly are on multiple medications which can further

cause susceptibility to decay or other oral health complications. Dry mouth is one leading cause of weakened tooth structure and creates an environment for decay.

While nursing homes intend to provide oral health care for their patients, this is not always possible for a variety of reasons, not the least of which is the absence of access to a dentist or hygienist. Inadequate staffing also leads to less time spent on oral health care for the individual resident. The logistics of providing this basic service can prove time consuming to long-term care staff.

During year one of the DentaQuest grant to the North Dakota Oral Health Program, surveys were conducted in communities throughout North Dakota to determine needs pertaining to oral health. One of the highest priority needs that surfaced in this year of study was the need for care to the elderly, particularly those in long-term care facilities. As a step towards obtaining oral health care, the DentaQuest grant partially funded a program to provide hygiene care on a monthly basis to selected long-term care facilities in the Bismarck-Mandan area. Data and information was compiled to demonstrate efficacy and profitability of the program to promote duplication by either individuals or other agencies. In the year ahead, a second agency duplicated the service and provided feedback on their program success or shortcomings. This program was be based solely on hygiene care and will not be paired with regular full-service dental care.

Bridging the Dental Gap (BDG), one of North Dakota's safety net clinics, started a project in September 2011 to provide dental care in long-term care settings. The BDG staff discovered much about what works and what doesn't throughout the project. Many of the observations and suggestions made in this document are based on the knowledge and experiences of the BDG staff.

SETTING UP

Equipment:

Scissor-Stand Chair
(Less expensive)

Portable Dental Unit
(Less expensive)

Portable Patient Chair
(More expensive)

Portable Dental Unit
(More expensive)

Portable Dental Light

Nomad
(Portable Dental X-ray)

Cordless Tooth Polisher

Dental equipment is expensive and portable equipment is no exception. The equipment needed to provide services is going to be dependent upon the practice objectives:

- Is the dentist going to provide full service at the mobile site?
- Is the dentist only going to do minimal exams?
- Is the hygienist going to be providing services?

Dental Equipment and Supplies for Full Services

Item	Quantity	Price	Total Cost
Portable carts and delivery systems and case	2	$7,000.00	$14,000.00
Portable Statum Sterilization Unit	1	$6,000.00	$6,000.00
Nomad portable x-ray unit and case	**1**	$8,000.00	$8,000.00
Dental x-ray program (software) ***	1	$16,000.00	$16,000.00
Laptop computer to view digital x-rays and storage	1	$2,800.00	$2,800.00
Sensor for x-rays	1	$5,000.00	$5,000.00
Portable halogen lights and cases	2	$1,200.00	$2,400.00
Cart to hold hand pieces and instruments (on wheels)	2	$700.00	$1400.00
Electronic scaler for hygienist unit	1	$700.00	$700.00
Curing light for dental unit	1	$900.00	$900.00
Portable patient hydraulic chairs & cases	2	$4,100.00	$8,200.00
Portable dentist chair	1	$600.00	$600.00
Portable hygienist chair	1	$600.00	$600.00
Portable assistant chair	1	$800.00	$800.00
Ultrasonic cleaner	1	$500.00	$500.00
Cavatron Pro Plus	1	$2,600.00	$2,600.00
Amalgamator –	1	$900.00	$900.00
Hand pieces – Asstd high speed and slow speed with fiber optics on half of these	9	$700.00	$5,600.00
Instrument Packs Asstd suppliers –12 per pack– for fillings and extractions. Includes but not limited to: scaler, mirror, explorer, forceps, asstd interproximal carvers, miscel carvers, ball burnisher, amalgam well, air/water syringe, amalgam condenser, varying size curette scoops, toffelmeyer's, acorn burnisher, dical instrument, amalgam carrier, articulating paper holder, etc.	10 packs	$55.00 per instrument	$5,500.00

TOTAL: **$82,500.00**

***If your offices already have a software program for digital x-rays (see highlighted item), then this additional program would not be necessary and this would decrease the total to:
$66,500.00

There is also a somewhat cheaper model of chair that is the "scissor stand" chair (see picture on previous page). The North Dakota Oral Health Program acquired these chairs for use in sealant projects and they are used extensively with the Mission of Mercy program. However, these are not effective chairs for heavier elderly patients (too low, not as adjustable, and don't "fit").

Dental Equipment and Supplies for Hygiene-Only (Streamline/Simplified version)

Item	Quantity	Price	Total Cost
Portable cart and delivery system and case	1	$4,000	$4,000
Cordless Hygiene prophy handpiece	1	$700	$700
Cart to transport items and plastic boxes for storage	1	$150	$150
Ultrasonic cleaner	1	$500	$500
Ultrasonic scaler	1	$750	$750
Portable hygienist chair	1	$600	$600
Hand pieces – Asstd	5	$700	$3,500
Instrument Packs Asstd suppliers –10 per pack– Hygiene packs	6 packs	$50 per instrument	$3,000

TOTAL: $14,200

In addition to all the items in the previous two equipment lists, there are obviously minor supplies which would need to be included at each visit: gloves, prophy paste, floss, toothbrushes, dental toothbrushes, implant toothbrush/cleaners, filling materials, bibs, etc.

You will note in the hygiene-only list that for the hygienist a number of the pieces of equipment are missing. Most importantly there is no chair for the patient. The chairs utilized in the full service list are hydraulic chairs that are too cumbersome for a hygienist to transport alone. For the hygiene-only program, the nursing facility should provide a reclining wheelchair. Most facilities have several on-hand. There also are no portable lights in the hygiene-only list. Dentists and hygienists all have head lamps and these work the best.

The dental cart unit in the full-service list has better suction and more amps than the one in the hygiene-only list. There is a need for the dentist to have a better portable vacuum than the hygienist alone. The lesser unit in the hygiene-only list is adequate for the hygienist. Neither of the options are "the best," but this is portable, mobile equipment, and it will not be exactly like what is used in a dental office.

Hygienists do not need to take sterilization equipment with them. They can simply add their instruments/hand pieces, etc., to the sterilization process when they return to the office. This cuts back on one more piece of equipment.

Cost of equipment will be one of the hurdles to surmount, and will be addressed in a later section of this informational plan.

STAFFING:

The private dental practice will need to determine their personal staffing patterns. Will you use an existing hygienist from your staff to provide care during "down time" at your own practice? Will you hire a part-time hygienist to provide this additional care? Will this new hygienist become a regular employee of the practice or an "independent contractor?" (This question would involve taxation issues that perhaps could be addressed for you by a tax advisor.) This will be dependent on the private practice's goals for providing care to the elderly.

Using an existing hygienist allows the flexibility of keeping a hygienist busy during times the dentist is out or during days that they do not usually work. Are there Fridays or some day of the week that is slower than others for the hygiene schedule? Does the dentist plan some vacation time or continuing education time on a regular basis that would work as a routine time for the hygienist to be "out of office" providing care at a long-term care facility?

Hiring a new part-time hygienist would allow some expansion of the practice and would allow for availability to provide the services on a more frequent basis. There are many options to hire hygienists within the state of North Dakota as there are currently more hygienists than positions available. Many who are employed at another type of business may wish to keep their hands in the hygiene pool and be willing to work at both. This additional part-time hygienist also may be utilized as fill-in for the regular staff hygienist when she/he is out sick, or for vacation and maternity leaves.

A good alternative might be to start out with existing staff and then if, and when, this service grows, hire additional hygiene staff.

Bridging the Dental Gap hired an additional hygienist who works at another dental office part-time. She handles her own scheduling with the long-term care facilities and this allows her to coordinate with her regular dentist and the elderly care program.

North Dakota dental regulations allow hygienists to provide care under General Supervision, which does not require the presence of a dentist in the facility. General Supervision is defined in the Administrative Rules Definitions as "the dentist has authorized the procedures and they are carried out in accordance with the dentist's diagnosis, if necessary, and treatment plan." By authorizing the procedure, this is viewed as meaning that there is a standing order for prophies to be completed on the nursing home/long-term care resident. This allows leeway for the hygienist to be available for patients that the facility requests to be seen even if they have not previously been seen by the dentist providing oversight. This area does require some discussion and further clarification of how far it extends. There are two conflicting areas in the rules that should be made to coincide. The dentist would need to have a "standing order" to provide the prophy care under any of the situations. This care could be to patients "of record," as well as new patients that the facility staff requests be seen.

The dentist may want to set aside time to do exams on the patients at the facility and determine any other needs. The hygienist may be able to suggest those with urgent care needs. Can the dentist provide cursory examinations without x-rays or would the patient need to be brought to the dental clinic first? This would need to be determined by the dentist. The dentist would then have a "standing order" for the hygienist to come in to provide care.

SETTING UP WITH THE NURSING HOMES/LONG-TERM CARE FACILITIES

Setting up a process for care will most likely be the easiest part of the entire process. The long-term care facilities are excited to have oral health care provided to their residents. They recognize the need and the flexibility that is offered by on-site services. They would be most receptive to more of the full-service care rather than just hygiene, but they also are willing to work with you. The dentist will need to make some decisions about how he/she will provide any care that may be required (fillings, extractions, dentures, etc.). Will the patient need to be brought to the dental offices or will there be some care that can be provided in the long-term care setting?

Contact should be made with the Head Administrator and Director of Nursing. A meeting should be scheduled to discuss your "proposal." Don't be surprised if they want you to start as soon as possible. Usually, an individual contact person will be designated by them to arrange appointments and determine which residents will be seen first. This person is crucial. It should be clear that the facility staff should make contact with the families so consent to be seen (wherever there is a family member with guardianship) can be obtained. Facilities can send out letters to all families initially about the in-house service and have them "sign up" for care.

A location within the facility should be designated for care. Often this may be the beauty shop, which works great. The space should be large enough for all your equipment and must have access to water and not be carpeted.

Times are usually flexible unless patients have other medical commitments such as physical therapy, occupational therapy or dialysis. Usually these can be worked around.

WHAT TO EXPECT

A variety of dental needs will be discovered. Multiple decay needing fillings, extractions, broken teeth, broken dentures and partials, extremely poor oral hygiene, abscesses, etc. There will be some exceptions that do not require much care, but expect to see many oral health issues.

The dilemma facing the dental staff will be what to treat and what not to treat. Most of the patients cannot keep their mouth open for long periods of time and thus quadrant dentistry is out of the question. Picking only those problems which are symptomatic and causing pain may be the best option. In some cases, family will request that you extract broken teeth and in other cases they will decline care for a variety of reasons. For those who are quite elderly this is probably the best option. Questions to ask would be:

1. Will the patient actually use a new denture?
2. Have they not worn one for some time?
3. Are they willing to use an existing one?

Patients may, on certain days, not be able to cooperate with services being provided. Staff will need to be flexible and move on to next patient; however, don't give up as the next time may be better. Certain elderly individuals may have better times of the day when they are more able to cooperate.

Many patients have some degree of dementia. These patients still need care, but perhaps the care needs to be done in steps. Whatever can be done is better than nothing. Keeping calm, speaking softly, keeping low or at their eye level are all strategies for dealing with patients with dementia. Continued talking can be distracting. It may take a lot of interpersonal skills to cope with these patients.

These dental visits are looked forward to by many of the patients. This is a social time for them, and they often like to talk. Some patients may come early and make the occasion into a "coffee klatch" with everyone sharing stories, including the hygienist.

The facility staff will provide patient records including names, ages, insurance information, family contacts, diagnoses and medications. From these it is usually easy to determine if any of the patients require premedication for simple cleanings. This information forms the basis of the chart information. Most dentists are aware of these forms as the facilities usually bring this information to the private offices where medical or dental treatment is provided. The Long-term care staff determines who needs to be seen for initial appointments. After that, the hygienist can expedite recalls. Patients are transported by the facility staff to the treatment site. Hygienists will complete forms for the center, as well as for his/her clinic.

After each visit, a comprehensive list is provided to the Director of Nursing or to the designated contact person about who was seen, services provided and when the individual should be seen again (i.e., 3 to 4-month recall for Medicaid, 6-month recall for private pay or as family wishes). This is also the time to share information that the hygienist noted on the patient's chart about a need to refer for dental care (either trip to dental office or in the facility if services can be provided there). There is better follow-through when the information is recorded both on the sheets that go back to the nursing station and on the summary provided to the contact person. A sample Patient Information Form is provided on the next page. This sample is for full-service visits, not just for the cleaning report.

Missouri Slope

Patient Information Form

Dental Exams, etc.

October 31, 2013, Only one day this month – water was shut off

Patient Name	Follow-up
	Exam and x-rays completed. Needs cleaning and 2 fills and one extraction.
	Exam and x-rays. Needs cleaning and 2 fillings.
	Did not see. Something came up and daughter could not be there so they asked us to wait until next time.
	Checked Dentures. Checked soft tissue and cancer screening. Needs reline for upper and lower dentures. Will send fee quote.
	Adjusted denture.
	Patient refused treatment. Will try again another time.
	Checked. Needs new partials. Will send quote to daughter for lower partial. Then will get impression for upper and lower if decide to proceed. Evidently Mandan Care Center lost her upper and they will pay for replacement.
	Cleaning. Has one filling left to do. Can R/S cleaning in February.
	Limited exam. Checked for sores. Will pre-auth for upper and lower partial. Family needs to let us know if they wish to proceed.
	Extracted multiple teeth. Will start denture at next visit. Schedule in November. Dr. Luger will work out how to do try in's etc.
	Exam and x-rays. Checked dentures. Soft tissue check. Needs a filling on one tooth. (She has 2 left and these are anchors for the lower partial.) Dentures fit well. Cleaned dentures.
	Denture adjustment. Patient requests a reline. Will pre-auth for this. May not be eligible as she has a reline last year.
	Filled large filling #14. Needs a cleaning and 3 more fillings.
	Impression for dentures. Other appointments scheduled at office – each about a week apart.
	Did not come in. Schedule for cleaning either with us or with Chantal.

BILLING – Private Pay and Medicaid

Contrary to what was originally thought, North Dakota's long-term care residents are not predominantly Medicaid patients, at least not in the Bismarck-Mandan area. Here, the ratio is about 40 percent Medicaid and 60 percent private pay. There are some patients who are on Medicare stays, but these are only on a temporary basis.

With 60 percent being private pay, this increases the need for communication with families both by the dental office and facility staff. There is usually not any prepayment and the billing is after the fact. This may not be in accordance with your usual payment practices. It does occasionally lead to some collection issues, but it is not typically very extreme. There are only a handful of patients that have dental insurance coverage.

Private-pay patients may only want semi-annual cleanings rather than quarterly and this would need to be monitored.

Since Bridging the Dental Gap (BDG) is a nonprofit dental clinic, it has provided the private-pay patients with services at a discount (up to 50 percent on some of the services). This would not have to be standard for a private practitioner, but it was in keeping within the guidelines of the BDG clinic.

Billing Medicaid

For most services, you will bill Medicaid in your usual manner. However, in order to provide more frequent services by the hygienist for cleanings, it is necessary to have the patient placed on a "Frequency List." Medicaid Frequency Lists allows the patient to have cleanings at three to four month intervals. A pre-authorization claim for cleaning (prophy) must be submitted along with a letter requesting the authorization to place the patient on a Frequency List. This only has to be submitted once. If they are on the list, they stay on the list.

The Medicaid letter needs to have specific information about the patient and explain the reason that the patient needs to be seen more frequently. This applies to patients in your practice who have other issues and not just nursing facility patients.

A sample letter is included on the following page. If the patient is on medication that causes dry mouth or other complications that should also be noted.

Medicaid will return the preauthorization with a number and notation that patient has been placed on frequency.

1223 South 12th Street, Suite #1 – Bismarck, ND 58504
Telephone (701) 221-0518

Bridging the Dental Gap

April 3, 2012

To: Medicaid Pre- Authorization Frequency Lists

Re: XXXXXXXX
MC # 0000000

We would like to have Jane Doe placed on a frequency list to allow cleanings and exams on 3 to 4 month basis.

She is a resident of a nursing home. She cannot provide adequately for her oral hygiene needs and is not able to prevent oral health problems. She has mild dementia, anemia, kidney disease and diabetes, and cannot adequately care for herself. Although she has some assistance with her general hygiene, it is not sufficient to deter decay and plaque build-up. She has all of her lower teeth remaining and would benefit from frequent cleanings.

Sincerely,

Marcia Olson
Clinic Manager

Medicare and Dental Payment

Although it is a complicated process, there is a means to tap into Medicare to assist with payment for dental services. The coverage involves use of Medicaid and Medicare to cover the dental and residential payments. It has not been necessary in North Dakota since North Dakota Medicaid does cover adults, including the geriatric population, for dental care. There are only a few items that Medicare actually covers and it does not include regular dental care or restorations.

COST DATA

Income vs Expense

Cost data was prepared for a hygiene-only program, not the full-service program.

A hygienist goes to the facility approximately four to four-and-a-half hours each date of service. During that time, usually five to six patients are seen, depending on needs and cooperation levels.

The hygienist's costs will depend on the hourly payment being made. The average hygienist cost for 2012, according to North Dakota Job Service (and those reporting), was $30.50 the cost example below uses a $30.00 per hour cost.

The Medicaid reimbursement rate for cleanings is currently $52.72 the Blue Cross Blue Shield payment is $92.00, although the BC/BS rate represents a percentile payment, it is used as the charge rate for private practice.

Costs

Wages	**$30 x 4.5 hours**	**$ 135.00**
Benefits	**(MC, FICA, Unemp, Ret)**	**15.00 (**not independent contractor)
Supply costs		**50.00** (high estimate)
Total:		**$ 200.00 per day**

Income

3 prophies on Medicaid patients	**$ 158.16**
3 prophies on private patients	**$ 276.00**
Total Income:	**$ 434.16**

While this may not represent a huge profit, it does cover operational costs and allows for some leeway. It does not include an allowance for the equipment but that will be covered in a separate section.

This section has addressed only the direct income from the cleanings. It does not estimate the income that may also come from the residents of the center who come to your facility for other treatment. The payment that might be received from those services would be able to offset some of the other costs (equipment, paperwork, etc.) and provide additional income.

The patients who are seen in the facility offer a number of opportunities for building a practice. As more dentists come to North Dakota, there have been some claims that there are too many dentists. If this is the case, the elderly care practice offers a unique opportunity to expand a new practice or at least assure some income for the new practitioner. For established dentists who are feeling a “squeeze,” it also offers a new income stream that could be built upon with some planning and imagination. For the older dentist who is nearing retirement, this might be an ideal means of stepping back from the main practice, but still helping to bring in new patients. For the altruistic dentist (young or old), this is an unmet need that goes to the core of giving back. This is truly an access-to-care issue that each can meet. If each dentist will do some part, then together a lot can be achieved.

There is a large amount of dental work that needs to be done, whether it is within the facility or by patients being brought to your facility.

Bridging the Dental Gap has reached the maximum number of facilities that can be served while still maintaining the regular clinic. Northland Health will be doing the same. Dentists will be doing the initial screening with the hygienist to follow. There are still many areas that remain untouched and ample opportunity for the practitioner willing to try.

BILLING FOR SERVICES

The dentist will be responsible for billing for services to both the private pay, insured and Medicaid covered patients. A hygienist cannot bill for the services and get paid by Medicaid or insurance under current rulings; therefore, the dentist's office would do the billing and collection. The dentist would then receive the income and pay the hygienist, either as an employee or independent contractor with a specific agreed upon amount.

NURSING HOME STAFF INTERACTION

Ideally the dentist and/or hygienist will maintain good interaction with all the long-term care facility staff, working to become members of the team that is providing care to the resident.

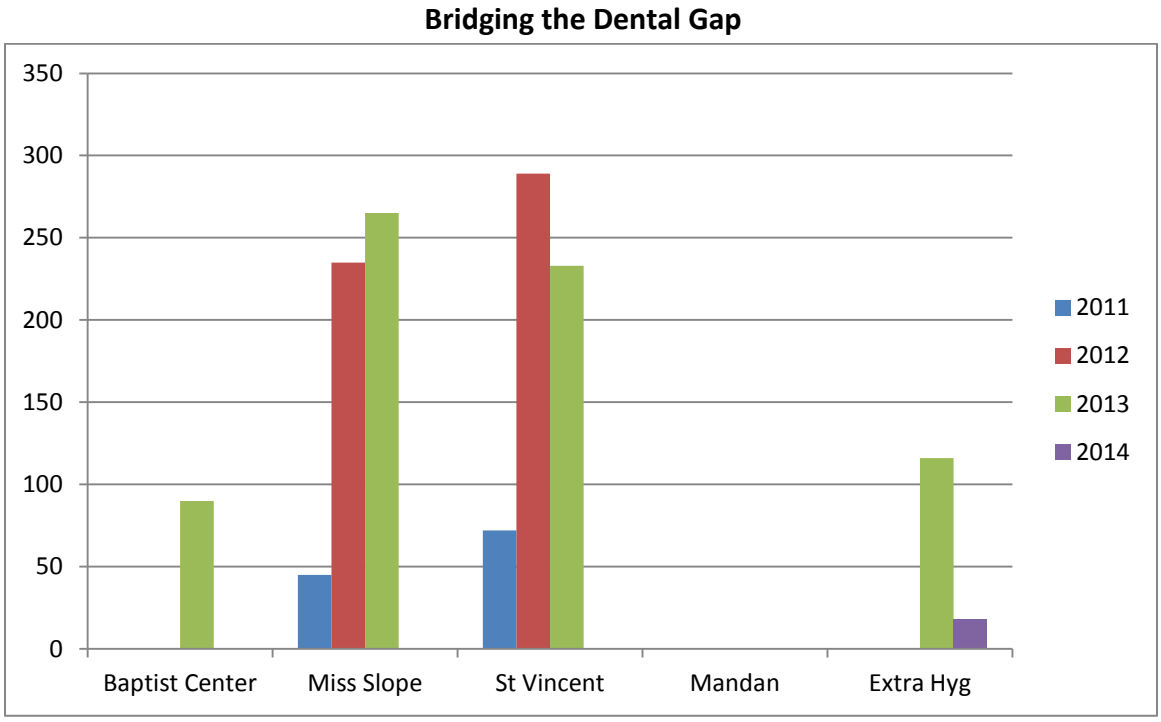
Even more important, would be helping to establish some training programs and continuing education for facility staff in oral health care for the elderly. There are some pre-made programs that could be used, staff could develop their own, or a combination could be used.

The Nursing Directors have been open to having in-service trainings. This is sometimes difficult to arrange due to their staff rotation hours; however, it is still something that the dental staff should strive to achieve.

SMILES FOR LIFE

Smiles for Life is a great program that offers materials and good information for use both by the hygienist and the long-term care staff. There are training modules available for geriatric oral health and general oral health. These modules provide CEU credits for those completing them and are most appropriate for nursing staff. There is no cost for use of the programs or information. The hygienist or dentist can freely use the information, slides, and other materials in their in-service trainings. This makes setting up an in-service very simple for the dental staff. The website is www.smilesforlifeoralhealth.org. Encourage the long-term care staff to visit the website and complete the Smiles for Life training modules.

LONG-TERM CARE REPORT



Bridging the Dental Gap provided care at four facilities as of 2014. The graph shown above only represents information as of January 15, 2014. Extra Hygiene refers to patients seen by the hygienist at a separate time from the dates that the dental team provided care. The Extra Hygienist sees roughly six patients at each setting and goes to each facility once or twice a month, as needed. The numbers shown represent patient encounters (as opposed to actual individual patients). The total encounters in all centers since the program began in September 2011 through 2013 are 1,363.

MALPRACTICE INSURANCE

One of the concerns of most dentists seems to be the malpractice insurance piece. If the dentist is providing a standing order, ultimately his/her insurance will be the one that covers a hygienist in these circumstances. Most hygienists who belong to their state and national association also have malpractice insurance built into their dues. This also can be expanded through their Hygienist Association.

North Dakota does not have a Collaborative Practice licensure provision for hygienists that outlines what may or may not be put into a contract. This area would be worth pursuing with

the North Dakota State Board of Dental Examiners to broaden the hygienists' ability to provide services and be responsible for some of their own insurance and supplies, etc.

Since the hygienist is only providing prophies/cleanings, the issue of malpractice should be minor. They are not providing root planing or scaling or administering any anesthetic at the facility without a dentist present.

PROBLEM SOLVING

1. **Families**
   Dealing with the families is a major issue. Some want to just be kept in the loop and others want to be present for each appointment. There is some paperwork involved in managing these issues. While the nursing homes are set up to get releases and consents, this is not always done in a timely manner. It depends on the facility and the numbers. This can raise issues, particularly with private pay patients. Don't expect that the facility will always have done their homework.

2. **Transportation - Equipment**
   This section deals with transportation of your equipment to and from the facility. In the hygiene-only scenario, the equipment is easily managed by the hygienist alone. In the full–service scenario, the equipment will need to be transported via a trailer, small truck or very large van. This will add to the cost of services.

3. **Transportation – Resident**
   If you opt for the resident to receive his/her regular care at your facility and just the extra hygiene services at the long-term care center, then the facility will need to transport the resident to your offices. This creates additional problems and concerns such as length of time at your facility, transferring to chair, length of appointments, frequency of visits. Does the care facility offer transportation and how frequent?

4. **Regular Services**
   How do you plan to provide for fillings, extractions and denture care? If your hygienist sees a problem, the facility staff sees a problem, or you find a problem on your initial screening, will you be open to providing the care?

5. **Dentists "on-staff"**
   In some areas of the country (not North Dakota at this time), there are dentists who are considered to be "on-staff" at long-term care facilities. These dentists agree to see and

provide care for all patients at the facility. In return, a "stipend" is paid to that provider from the facility. This has some inherent expectations that may be difficult to meet. Additionally, there will be facilities that will remind you that "way back when" there used to be dentists on staff who helped to screen the patients upon admission for oral health needs. That was a previous practice and is not currently done. There is still some desire to return to this. This topic comes up as often as reminiscing about dentists who used to be on-call at emergency rooms. These are all issues to be addressed on an on-going basis.

6. **Equipment Costs**

This is one of the biggest issues that needs to be addressed regardless of the scenario. The solutions are not simple, but also not insurmountable. Several dentists could pool funds and share equipment. While this would be a logical suggestion, it also lends itself to conflict without a "neutral party" involved unless the dentists are used to practicing together and helping each other.

Because of the overall need throughout the state for these services, the legislature might be convinced to provide funding for equipment that would be strategically located and then shared with any dental staff that is willing to provide the services. The legislature could be approached jointly by the North Dakota Dental Association, the Long-term Care Association and the North Dakota Oral Health Coalition. This would be an ideal solution that could establish access across the state, not just in one area. A bill could be proposed for $200,000 to $250,000 that would purchase equipment to be placed in 10 parts of the state for elderly care. The North Dakota Oral Health Coalition could oversee the equipment and set up guidelines for use and repair and operate a "lending library" type set up. It would be necessary to have some commitment from dentists across the state that would be willing to use the equipment in long-term care facilities. Another option that has been used in other states is that the long-term care facilities would own and set up in-house dental clinics. This would be the most ideal but also the least likely to occur. Not only is space limited at most facilities, it would most likely have to be an open setting to "all comers." This would probably be restricted to a dentist signing on as an "in-house" dentist. Additionally, the facilities do not have the funds to set up permanent dental clinics.

The North Dakota Oral Health Coalition has received its 501©3 status. It could look at finding a grant that might help to subsidize the equipment or seek contributions/donations.

By having the equipment held by an impartial entity, any dentist would have the opportunity to step forward to provide this type of care.

While there may be issues with all these options, they are worth pursuing.

7. **Long-term Care Needs**
   Don't bite off more than you can chew. You will most likely have multiple facilities vying for your time and practice once they hear that you have started offering services at long-term care facilities. You should pick one or two spaces near your office and start there. There is more than enough need to go around and you will also still have a regular practice to run.

Additional Sources of Information that may be Helpful

Journal of Dental Education September 2005

"Access to Dental Care Among Older Adults in the United States"
Teresa Dolan, DDS, MPH
Kathy Atchenser DDS, MPH
University of Florida

American Journal of Public Health May 2004

"Oral Health Care Services for Older Adults – a Looming Crisis"
Ira B. Lamster, DDS

Medicare Policy June 2012

"Oral Health and Medicare Beneficiaries: Coverage, out-of-pocket spending and Unmet Need"
Kaiser Family Foundation

Journal of Conservative Dentistry July-September 2011

"Geriatric Restorative Care – the need, the demand and the challenge"
Comment: Good article on treatment planning for the elderly

Dental Considerations for the Geriatric Patient

Online course
www.netce.com/coursecontent.php?courseid=842

Geriatric Dentistry: Reviewing for the Present, Preparing for the Future

dentalcare.com continuing Education
http://www.dentalcare.com/en-US/dental-education/continuing-education/continuingeducation-landing.aspx

Dental Considerations for the Frail Elderly (Apple Tree Dental)

http://www.mohc.org/files/SCD Frail Elderly 9-11-02 Helgeson (2).pdf

Dentistry Today October 2008

Preparing Your Office and Team for the Care of Geriatric Patients
www.dentistrytoday.com/hygiene/1171

Geriatric Dentistry: Caring for Our Aging Populations

October 2014
Textbook
Paula Friedman

Providing Dental Care for Older Adults in Long-term Care 2006

PowerPoint
http://www.med.upenn.edu/gec/user_documents/10_Oral-Heatlh-Handouts24.pdf

RDH

"Resources for geriatric dementia" Lynne Slim
www.rdhmag.com/articles/print/volume-33/issue-9/columns/resources-for-geriatric-dementia

Journal for the American Society for Geriatric Dentistry

A number of good articles to review

Family Caregiver Alliance

"Caregivers Guide to Understanding Dementia Behaviors"
https://caregiver.org/caregivers-guide-understanding-dementia-behaviors

Center for Oral Health March 2013

"Guidelines for Providing Dental Services in Skilled Nursing Facilities"